WELCOME TO TUFTS HEALTH PLAN

Please complete all of the member sections of the membership application in full. Failure to do so could delay enrollment. You must be a Massachusetts resident to enroll in any of these plans.

Member Sections

Personal Information - Complete all enrollment information. If your plan requires the selection of a primary care physician (HMO) please be sure to fill out this section for all members, including dependents. Note: Your Social Security number is not required for enrollment.

If you have problems finding a primary care physician, you can visit our website, tuftshealthplan.com/enrollnow.

Dependent children - Dependent children may be covered until their 26th birthday. Please be sure to fill out all appropriate information for each dependent, including primary care physician (if applicable).

Other Health Coverage - If you have other insurance (including Medicare) please check the correct box and fill in the additional information about your other insurance. If you do not have other insurance, be sure to check the "no" box.

When the application is complete

PLEASE RETURN THIS FORM TO:
Tufts Health Plan
554 Main Street
P.O. Box 15014
Worcester, MA 01615-0014

Member Please Note:

By enrolling, you certify that: (a) you meet the definition of an eligible individual under Massachusetts law; (b) you are not eligible for Medicare or Medicaid unless you are enrolling during a regular open enrollment period; and (c) you agree to and understand that if you or any of your enrolled dependents (1) obtain a health care benefit or payment that you know you are not entitled to receive or be paid; or (2) knowingly present or cause to be presented, with fraudulent intent, information on this application, or a claim that contains a false statement, you may be liable for the full amount of health care benefits or payments made and for reasonable attorney's fees and costs, including cost of investigation. In addition, we may terminate your coverage.

Tufts Health Plan arranges for the provision of health care services, but does not provide health care services. Tufts Health Plan arranges for the provision of health care through agreements with independent health care professionals and with hospitals throughout the Tufts Health Plan service area. These providers are independent contractors and not employees, agents, or representatives of Tufts Health Plan for any purposes.

Select Network Disclosure Notice
Provider Network Access

Limited Provider Network

Select Network plans provide access to providers that are not the same as the Tufts Health Plan's standard provider network.

Your member identification card will say Select Network on it. The designation Limited will be on the top right-hand side of the card that applies to the health benefit plan you have chosen.

I understand that: I may not change plans during a policy year because of changes to the provider network; and the plan provides access to providers that may not be the same as Tufts Health Plan's standard provider network. In addition, I have reviewed the Select Network provider directory or online search tool and understand that this plan only provides access to covered benefits from the providers in the Select Network directory. I understand that it is my responsibility to ensure that a provider I voluntarily choose is enrolled in the Select provider network before obtaining care. In choosing the Select plan, I understand I will be required to choose a different provider for treatment if a provider I now see is not enrolled in the Select provider network. Finally, I certify that I have received the guide before beginning and completing the application/enrollment process.

My signature on the application certifies that I have read and understand the above and that I have received the guide.

Need Help?

If you need assistance filling out this form, our member specialists are here to help. Call 800-957-6596. You can also log onto our website at tuftshealthplan.com/enrollnow for more information.

TUFTS Health Plan

MEMBER ENROLLMENT FORM

Please print or type. Please be sure application is completed in full to ensure enrollment.

FAILURE TO COMPLETE THE UNDERLINED SECTIONS MAY CAUSE A DELAY IN ENROLLMENT.

CHOOSE PLAN TYPE

- ☐ HMO Basic 25
- ☐ Advantage HMO 1000
- ☐ Advantage PPO 1500
- ☐ Select Advantage HMO 1500
- ☐ Advantage HMO Saver 2000
- ☐ Advantage HMO 2000 with 80% coinsurance

Member Section

☐ New Enrollee or ☐ Qualifying Event for Changes to Plan (MUST specify) ____________ Qualifying Event Date____________ Requested Effective Date of Coverage____________

1. E-mail
2. Have you or anyone in your family used tobacco products, e.g., cigarettes, chewing tobacco, etc., in the last 12 months? ☐ Yes ☐ No
3. Last Name
4. First Name
5. Middle Initial
6. Social Security Number (SSN)
7. Mailing Address (Home Address)
8. Apt#
9. City
10. State
11. ZIP
12. Gender ☐ M ☐ F
13. Date of Birth month / day / year
14. Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Domestic Partner
15. Type of Coverage Requested ☐ Individual ☐ Subscriber/Spouse ☐ Subscriber/Child or Children ☐ Family
16. Primary Care Physician
17. PCP ID#
18. Check if currently used for primary care ☐
19. Home Telephone ( )
20. Work Telephone ( )
21. Fitness Center
22. Primary Language

Members Enrolling (Last name, if different)	Sex M/F	Date of Birth	Social Security Number	Fitness Center	Choose a **Primary Care Physician** for each member	Tufts Health Plan Affiliated Hospital	Check if currently used for primary care	PCP ID#
23. Spouse/DP			- -					
24. Child/Dependent			- -					
25. Child/Dependent			- -					
26. Child/Dependent			- -					
27. Child/Dependent			- -					
28. Child/Dependent			- -					

29. Do you or someone else covered under this insurance policy have other health insurance coverage at the same time your Tufts Health Plan policy is in effect? ☐ Yes ☐ Yes (Medicare) ☐ No

Name of Health Plan	Name of Plan Holder	Health Plan Number	Effective Date	Names of Family Members Covered

30. Is spouse employed? ☐ Yes ☐ No If yes, Name and Address of Employer

31. Please check If you are using additional membership applications for additional dependent children ☐

The information supplied on this form is true and complete. I assign benefits to Tufts Health Plan providers, which means that Tufts Health Plan is authorized to make payment directly to Tufts Health Plan providers for services rendered to me (us). I grant Tufts Health Plan any legal right that I (or we) may have to recover the cost of services for an illness or injury caused by someone else when these services have been or will be paid by Tufts Health Plan. I understand that calls to the member services department may be monitored for quality assurance. I understand that the benefits for which I (we) are eligible are those described in the applicable member benefit documents.

If you are enrolling in a Select Limited Provider Network Plan:
I am enrolling in a Select Limited Provider Network Plan and certify that I have read and understand the disclosure notice on the front of this application.

Signature (required): ______________________ Date: ____________